Physician Services

Laboratory and Radiology

wisconsin Medicaid and BadgerCare

Information for Providers

Department of Health and Family Services

Important Telephone Numbers

The Wisconsin Medicaid Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility.

Service	Information Available	Telephone Number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:30 a.m. - 5:00 p.m. (M-F)

* Please use the information exactly as it appears on the recipient's identification card or the EVS to complete the patient information section on claims and other documentation. Recipient eligibility information available through the EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

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Preface

The Wisconsin Medicaid and BadgerCare Physician Services Handbook is issued to physicians, physician assistants, physician clinics, nurse practitioners, nurse midwives, rural health clinics, and federally qualified health centers who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. As of January 2003, BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid and BadgerCare publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Recipient Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on the methods of verifying eligibility.

Handbook Organization

The Physician Services Handbook consists of the following sections:

- Medicine and Surgery section.
- Laboratory and Radiology section.
- Anesthesia section.

In addition to the Physician Services Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid and BadgerCare

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-498 — Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Department of Health and Family Services, Chapters HFS 101-108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations. Handbooks and *Updates* organized by provider type, maximum allowable fee schedules, helpful telephone numbers and addresses, Remittance and Status messages, and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

www.dhfs.state.wi.us/medicaid/
www.dhfs.state.wi.us/badgercare/.

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

General Information

The Laboratory and Radiology section of the Physician Services Handbook includes information for ***physicians, physician assistants, and physician clinics*** regarding covered services, reimbursement methodology, and billing information that applies to fee-for-service Medicaid providers. (If you are a Medicaid HMO network provider, contact your managed care organization for information about their requirements.)

Wisconsin Medicaid reimburses only for those services that are medically necessary, appropriate, and, to the extent that alternative services are available, the most cost effective.

What Are Medicaid-Covered Physician Services?

Physician services covered by Wisconsin Medicaid are:

- Diagnostic services.
- Preventive services.
- Therapeutic services.
- Rehabilitative services.
- Palliative services.

Wisconsin Medicaid reimburses only for those services that are medically necessary, appropriate, and, to the extent that alternative services are available, the most cost effective.

Refer to HFS 107.03 and to HFS 107.06(5), Wis. Admin. Code, for services ***not covered*** by Wisconsin Medicaid. Refer to the Covered and Noncovered Services section of the All-Provider Handbook for a partial list of the noncovered services.

Provider Eligibility and Certification

To be certified by Wisconsin Medicaid, physicians must be licensed to practice medicine and surgery pursuant to ss. 448.05 and 448.07, Wis. Stats., and chapters Med 1, 2, 3, 4, 5, and 14, Wis. Admin. Code.

Physicians are asked to identify their practice specialty at the time of Medicaid certification. Reimbursement for certain services is limited to providers with specific specialties.

Types of Provider Numbers

Wisconsin Medicaid issues all providers, whether individuals, agencies, or institutions, an eight-digit provider number to bill Wisconsin Medicaid for services provided to eligible Medicaid recipients. A provider number belongs solely to the person, agency, or institution to whom it is issued. It is illegal for a Medicaid-certified provider to bill using a provider number belonging to another Medicaid-certified provider.

A provider keeps the same provider number in the event that he or she relocates, changes specialties, or voluntarily withdraws from Wisconsin Medicaid and later chooses to be reinstated. (Notify Provider Maintenance of changes in location or of specialty by using the Wisconsin Medicaid Provider Change of Address or Status form, HCF 1181, which may be obtained from the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* or by calling Provider Services at (800) 947-9627 or (608) 221-9883.) A provider's identification number is not reissued to another provider in the event of termination from Wisconsin Medicaid.

Wisconsin Medicaid issues three types of provider numbers to physicians, physician assistants, and physician clinics. Each type of provider number has its designated uses and restrictions. The three types are:

- Billing/performing number.
- Group billing number.
- Nonbilling/performing number.

Billing/Performing Provider Number (Issued to Physicians and Residents)

Wisconsin Medicaid issues a billing/performing provider number to physicians and residents that allows them to identify themselves on the CMS 1500 claim form as either the biller of services or the performer of services when a clinic or group is billing for the services.

Group Billing Number (Issued to Clinics)

A group billing number is primarily an accounting convenience. A physician clinic or group using a group billing number receives one reimbursement and one Remittance and Status (R/S) Report for covered services performed by individual providers within the clinic or group.

Individual providers within a physician clinic or physician group must also be Medicaid certified because physician clinics and groups are required to identify the performer of the service on the claim form. (The performing provider's Medicaid provider number must be indicated in Element 24K of the CMS 1500 claim form when a group billing number is indicated in Element 33.) A claim billed with only a group billing number is denied reimbursement. However, the following groups are *not* required to indicate a performing provider:

- Pathology groups.
- Radiology groups.

Refer to the CMS 1500 claim form completion instructions in Appendix 5 of this section for more information.

Nonbilling/Performing Number (Issued to Physician Assistants)

Wisconsin Medicaid issues a nonbilling/performing provider number to physician assistants because they must practice under the professional supervision of a physician to be eligible providers. Physician assistants must be supervised by a physician to the extent required under state regulation and licensing statutes, medical practices statutes, and Med 8, Wis. Admin. Code. A nonbilling/performing provider number may not be used to independently bill Wisconsin Medicaid but may be used in one of two ways:

1. If the claim is to be paid to the supervising physician, enter the supervising physician's name and provider number in Element 33 of the CMS 1500 claim form, and the physician assistant's nonbilling/performing provider number in Element 24K.
2. If the claim is to be paid to the clinic, enter the clinic's name and number in Element 33, and the physician assistant's number in Element 24K.

Recipient Eligibility

Eligibility for Wisconsin Medicaid

Medicaid providers should ***always*** verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage.

Medicaid providers should ***always*** verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage.

Recipients in the following benefit categories have limitations in their Medicaid coverage:

- Qualified Medicare Beneficiary only (QMB only).
- Specified Low Income Medicare Beneficiary only.
- Qualified Working Disabled Individual.
- Presumptive eligibility for pregnant women.
- Illegal (undocumented) aliens.
- Tuberculosis-related.

Refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for more information about these restricted benefit categories and other eligibility issues, such as Lock-In status.

Claims submitted to Wisconsin Medicaid for services covered by the recipient's Medicaid managed care program are denied.

Eligibility information for specific recipients is available from Wisconsin Medicaid's Eligibility Verification System (EVS). The EVS is used by providers to verify recipient eligibility, including whether the recipient is enrolled in a Medicaid HMO, has commercial health insurance coverage, or is in a restricted benefit category. Providers can access EVS a number of ways, including:

- Automated Voice Response system.
- Magnetic stripe card readers.
- Personal computer software.
- Provider Services.
- Direct Information Access Line with Updates for Providers.

Refer to the Provider Resources section of the All-Provider Handbook for more information about these methods of verifying recipient eligibility. For more information about recipient eligibility itself, refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook.

Medicaid Managed Care Coverage

Claims submitted to fee-for-service Medicaid for services covered by the recipient's Medicaid managed care program are denied.

Additional information regarding Medicaid managed care program noncovered services, emergency services, and hospitalization is located in the *Wisconsin Medicaid Managed Care Guide* and in the Covered and Noncovered Services section of the All-Provider Handbook. Call Provider Services at (800) 947-9627 or (608) 221-9883 to order a copy of the *Wisconsin Medicaid Managed Care Guide*.

Recipient Copayment

The copayment amount for each laboratory service is $1.00 per test. The copayment amount for each radiology service is $3.00 per procedure.

Copayment Maximum

A recipient's copayment is limited to $30.00 cumulative per physician ***or*** clinic (using a group billing number) per calendar year.

Copayment Exemptions

According to HFS 104.01(12)(a), Wis. Admin. Code, providers are prohibited from requesting copayment from the following recipient groups:

- Children under 18 years old.
- People in nursing homes.
- People in state-contracted or other Medicaid managed care programs receiving managed care covered services. Refer to the *Wisconsin Medicaid Managed Care Guide* for more information on services not covered by managed care programs.
- Pregnant women who receive medical services related to their pregnancy or to another medical condition that may complicate their pregnancy.

The following services are exempt from copayments:

- Emergency hospital and ambulance services and emergency services related to the relief of dental pain.
- Family planning services and supplies.
- Common carrier transportation, if provided through or paid for by a county/tribal social or human services department.
- Home health services.
- Injections and immunizations.
- Personal care services.
- Case management services.
- Outpatient psychotherapy services received that exceed 15 hours or $500, whichever occurs first, during one calendar year.

- Occupational, physical, or speech therapy services received that exceed 30 hours or $1,500 for any one therapy, whichever occurs first, during one calendar year.
- Hospice care services.
- Substance abuse (alcohol and other drug abuse) day treatment services.
- Respiratory care for ventilator-assisted recipients.
- Community support program services.
- Specialized medical vehicle services.

Copayment and Billed Amounts

Wisconsin Medicaid automatically deducts the applicable copayment amount from the reimbursement allowed by Wisconsin Medicaid. Do not reduce the billed amount on the claim by the amount of recipient copayment. This amount is indicated on the provider's R/S Report.

Refund of Recipient Copayment

In the event that medical services are covered by a third party, including a commercial HMO, and the provider collects copayment from a recipient, it is the provider's responsibility, not the responsibility of Wisconsin Medicaid, to refund the copayment amount to the recipient. The deduction of copayment as indicated on the provider's R/S Report for each claim processed is the copayment amount owed by the recipient to the provider.

Coordination of Benefits

Health Insurance Coverage

In most cases, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. If the recipient is covered under commercial health insurance, Wisconsin Medicaid reimburses that portion of the allowable cost remaining after commercial health insurance sources have been exhausted.

In some cases, Wisconsin Medicaid is the primary payer and must be billed ***first***. Payers secondary to Wisconsin Medicaid include governmental programs such as:

- Birth to 3.
- The Crime Victim Compensation Fund.
- General Assistance.
- Title V of the Social Security Act, Maternal and Child Health Services, relating to the Program for Children with Special Health Care Needs.
- The Wisconsin Adult Cystic Fibrosis Program.
- The Wisconsin Chronic Renal Disease Program.
- The Wisconsin Hemophilia Home Care Program.

Refer to the Coordination of Benefits section of the All-Provider Handbook for more information on services requiring health insurance billing, exceptions, the Other Coverage Discrepancy Report, and payers secondary to Wisconsin Medicaid.

Medicare Coverage

Recipients covered under both Medicare and Wisconsin Medicaid are referred to as dual entitlees. Claims for Medicare-covered services provided to dual entitlees must be submitted to Medicare prior to Wisconsin Medicaid.

In most cases, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service.

Wisconsin Medicaid requires physicians and physician assistants to be Medicare certified to provide services to dual entitlees. Physicians and physician assistants not certified by Medicare are required to be retroactively certified by Medicare for the date and the service provided if they held a valid license when the service was provided.

Providers must accept assignment from Medicare for claims for dual entitlees. The dual entitlee is not liable for Medicare's coinsurance or deductible.

Usually, ***Medicare-allowed*** claims (called crossover claims) are automatically forwarded

Qualified Medicare Beneficiary-only recipients are eligible ***only*** for Wisconsin Medicaid payment of the coinsurance and the deductibles for Medicare-allowed services.

by the Medicare claims processor to Wisconsin Medicaid for processing. Wisconsin Medicaid reimburses the provider for coinsurance and deductible within certain limits described in the Coordination of Benefits section of the All-Provider Handbook. Wisconsin Medicaid reimburses for coinsurance and deductible on crossover claims even if the service provided was not a Medicaid-covered service.

Medicare reimburses 100% of the approved fee for clinical laboratory services (e.g., those that appear on Medicare's clinical laboratory procedure allowable fee schedule), therefore, such services are not forwarded to Wisconsin Medicaid. Claims for nonclinical laboratory and radiology services are forwarded from *Medicare* to Wisconsin Medicaid for processing.

If the service provided to a dual entitlee is covered by Medicare (in at least some situations), but ***Medicare denied*** the claim, providers should submit a new claim to Wisconsin Medicaid and indicate the appropriate Medicare disclaimer code in Element 11 of the CMS 1500 claim form. Refer to Appendix 5 (Element 11) for a list of the Medicare disclaimer codes.

Qualified Medicare Beneficiary Only

Qualified Medicare Beneficiary-only recipients are eligible ***only*** for Wisconsin Medicaid payment of the coinsurance and the deductibles for Medicare-allowed services. Wisconsin Medicaid does not reimburse providers for services for QMB-only recipients that Medicare does not allow. Physicians must accept assignment from Medicare for claims for QMB-only recipients.

Abortions

Coverage Policy

In accordance with s. 20.927, Wis. Stats., Wisconsin Medicaid covers abortions when one of the following situations exists:

1. The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests, based on his or her best clinical judgement, that the abortion meets this condition by signing a certification.
2. In a case of sexual assault or incest, provided that prior to the abortion the physician attests to his or her belief that sexual assault or incest has occurred, by signing a written certification and provided that the crime has been reported to the law enforcement authorities.
3. Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior to the abortion, the physician attests, based on his or her best clinical judgment, that the abortion meets this condition by signing a certification.

Services Incidental to a Noncovered Abortion

Services incidental to a noncovered abortion are not covered by Wisconsin Medicaid. Such services include, but are not limited to, any of the following services when directly related to the performance of a noncovered abortion:

- Laboratory testing and interpretation.
- Recovery room services.
- Transportation.
- Routine follow-up visits.
- Ultrasound services.

Laboratory Services

Laboratory Certification Criteria

Wisconsin Medicaid verifies that laboratories are CLIA-certified before issuing a Medicaid provider billing number.

This handbook section contains policy and claims submission information for physician office laboratories. Wisconsin Medicaid defines a physician office laboratory as a laboratory that is maintained by a physician or clinic for performing diagnostic tests for the patients of the physician or clinic.

Physician office laboratories may submit claims for laboratory services under an individual physician's provider number or under a physician group provider number with a performing provider number.

Physician office laboratories that accept 100 or more specimens during a calendar year on referral from other physicians outside the clinic are certified by Wisconsin Medicaid as independent laboratories. Independent laboratories use the Independent Laboratory Services Handbook for policy and claims information. To obtain a copy of this handbook, refer to the Medicaid Web site (*www.dhfs.state.wi.us/medicaid/*) or call Provider Services at (800) 947-9627 or (608) 221-9883.

Clinical Certification for Laboratory Services

Congress implemented the Clinical Laboratory Improvement Amendment (CLIA) to improve the quality and safety of laboratory services. CLIA requires ***all*** laboratories and providers performing tests for health assessment or for the diagnosis, prevention, or treatment of disease or health impairment to comply with specific federal quality standards.

CLIA Enrollment

The federal Centers for Medicare and Medicaid Services (CMS), formerly HCFA, sends CLIA enrollment information to Wisconsin Medicaid. The enrollment information includes CLIA identification numbers for all current laboratory sites. Wisconsin Medicaid verifies that laboratories are CLIA-certified before issuing a Medicaid provider billing number.

CLIA Regulations

Wisconsin Medicaid complies with the following federal regulations as initially published and subsequently updated:

- Public Health Service Clinical Laboratory Improvement Amendments of 1988.
- 42 CFR Part 493, Laboratory Requirements.

Scope of CLIA

CLIA governs all laboratory operations including the following:

- Accreditation.
- Certification.
- Fees.
- Patient test management.
- Personnel qualifications.
- Proficiency testing.
- Quality assurance.
- Quality control.
- Records and information systems.
- Sanctions.
- Test methods, equipment, instrumentation, reagents, materials, supplies.
- Tests performed.

CLIA regulations apply to ***all*** Medicaid providers who perform laboratory services, including, but not limited to, the following:

- Clinics.
- HealthCheck providers.
- Independent clinical laboratories.
- Osteopaths.
- Physician assistants.
- Physicians.
- Rural health clinics.

CLIA Certification Types

The CMS regulations require providers to have a CLIA certificate that indicates the laboratory is qualified to perform a category of tests.

Physician clinics or groups with a single Medicaid group billing number, but multiple CLIA numbers for different laboratories, may wish to contact Provider Services to discuss various certification options.

The CMS issues five types of certificates for laboratories:

1. *Waiver certificate*. This certificate allows a laboratory to perform waived tests only. Refer to Appendix 2 of this section for a list of waived procedures, including those procedures that must be billed with a "QW" modifier.
2. *Provider-performed microscopy procedures certificate*. This certificate allows a physician, mid-level practitioner (i.e., nurse midwife, nurse practitioner, or physician assistant licensed by the state of Wisconsin), or dentist to perform microscopy and waived procedures only. Refer to Appendix 3 of this section for a list of CLIA-allowable provider-performed microscopy procedures.
3. *Registration certificate*. This certificate allows a laboratory to conduct moderate or high complexity tests until the laboratory is determined to be in compliance through a CMS survey performed by the Wisconsin state agency for CLIA.
4. *Compliance certificate*. This certificate is issued to a laboratory (for moderate and/or high complexity tests) after a CMS inspection performed by the state agency finds the laboratory in compliance with all applicable complexity-level requirements.
5. *Accreditation certificate*. This certificate is issued on the basis of the laboratory's accreditation by a CMS-approved accreditation organization. The six major approved accreditation organizations are:

    - Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
    - College of American Pathologists (CAP).
    - COLA.
    - American Osteopathic Association.
    - American Association of Blood Banks.
    - American Society of Histocompatibility and Immunogenetics (ASHI).

Use the CMS 116 CLIA application for program certificates. Providers may obtain CMS 116 forms from the address below:

Clinical Laboratory Unit
Bureau of Quality Assurance
Division of Supportive Living
PO Box 2969
Madison WI 53701-2969

Providers must notify the Clinical Laboratory Unit in writing within 30 days of any change(s) in ownership, name, location, or director. Also, providers must immediately notify the Clinical Laboratory Unit of changes in certificate types and within six months when a specialty/ subspecialty is added or deleted. Providers may reach the Clinical Laboratory Unit at (608) 266-5753.

The CMS regulations require providers to have a CLIA certificate that indicates the laboratory is qualified to perform a category of tests.

Covered Laboratory Tests

Laboratory Consultations

Physicians may be reimbursed for laboratory consultations only when the consultation is medically necessary and appropriate for the recipient's treatment. Consultation procedure codes are listed with type of service (TOS) "3" in Appendix 1 of this section. Laboratory consultations are reimbursable only when performed at the request of the attending physician and when the results are contained in a written report which becomes part of the recipient's medical record.

The referring physician's name and provider number must be indicated on the CMS 1500 claim form in Elements 17 and 17a, respectively.

Multiple Laboratory Tests

Multiple laboratory tests must be billed with a panel or aggregate procedure code (e.g., hemogram) when such a code exists in *Current Procedural Terminology* (CPT). This policy is monitored by Wisconsin Medicaid's claim review system, McKesson ClaimCheck®. Refer to the Billing and Reimbursement chapter of this section for more information.

Total reimbursement for multiple chemistry or other laboratory tests billed individually may not exceed the reimbursement rate established by Wisconsin Medicaid for the most closely related panel or aggregate code, as determined by the Division of Health Care Financing (DHCF). The provider's reimbursement may be corrected on a post-payment basis by Wisconsin Medicaid.

Multiple laboratory tests must be billed with a panel or aggregate procedure code (e.g., hemogram) when such a code exists in *Current Procedural Terminology* (CPT).

For example, an electrolyte panel (procedure code 80051) must include the following tests:

- Carbon dioxide (82374).
- Chloride; blood (82435).
- Potassium; serum (84132).
- Sodium; serum (84295).

If a provider performs all the above tests except the sodium test, each code must be individually billed to Wisconsin Medicaid and each will be reimbursed as a separate procedure. However, Wisconsin Medicaid may later reconsider the reimbursement and adjust it to equal the reimbursement rate for the electrolyte panel.

Urinalysis

When two or more of the services listed in the urinalysis section of CPT are performed on the same day for the same recipient by the same provider with a place of service (POS) code other than "1" or "2" (inpatient or outpatient hospital), they are reimbursed collectively at no more than the maximum fee amount for procedure code 81000 (Urinalysis, by dip stick or tablet reagent ... non-automated, with microscopy).

Routine urinalysis is included in the reimbursement for antepartum care and is not separately reimburseable. Refer to the Surgery Services chapter in the Medicine and Surgery section of the Physician Services Handbook for more information on obstetric services coverage.

Billing Laboratory Tests

Medicaid-Allowable Procedure Codes

Wisconsin Medicaid coverage of laboratory services is based on the procedure performed by the physician or his or her designee and is identified by the CPT or local procedure code that best describes the procedure performed.

Wisconsin Medicaid does not reimburse for all CPT codes (e.g., fertility-related services are not covered). In addition, the procedure code billed must be appropriate for the CLIA certification type indicated in the billing provider's Medicaid file. Refer to Appendix 1 of this section for Wisconsin Medicaid-allowable procedure codes and their appropriate TOS and POS codes.

Complete Procedure vs. Professional and Technical Components

Most laboratory services are performed and reimbursed as a complete procedure (TOS "5").

A relatively small number of laboratory procedure codes have technical (TOS "U") and professional (TOS "X") components. Nevertheless, these procedures are billed as a complete procedure (TOS "5") when both the technical and professional components are performed by a single laboratory. A ***written report*** must be produced and maintained in the recipient's medical record when one of these procedure codes (having technical and professional components) is billed with either a TOS "X" or "5."

At times the technical component is performed by the physician clinic but the professional component is performed by an outside physician or laboratory. In this situation, each provider bills and is reimbursed only for the service performed, as follows:

- The provider performing the technical component bills only the technical component (TOS "U").
- The provider performing the professional component bills only the professional component (TOS "X"). Remember that the professional component must result in a written report that is kept in the recipient's medical record.

The complete procedure (TOS "5") is not reimbursable to either provider in this situation.

The attending physician's clinical interpretation of laboratory results is not separately reimbursed because it is included in Wisconsin Medicaid's reimbursement for the physician-patient encounter (i.e., the evaluation and management service). However, the attending physician may be paid the clinical interpretation of a laboratory test if the attending physician is the sole provider of the professional component (e.g., if a cardiologist is the attending physician, he or she may be paid the interpretation of an EKG if he or she is the sole provider of the professional component).

Unlisted Procedures

Medicaid claims for an unlisted (nonspecific) procedure code require documentation describing the procedure performed. The documentation must be sufficient to allow the Medicaid chief medical officer to determine the nature and scope of the procedure and whether the procedure was medically necessary as defined in HFS 101.03(96m), Wis. Admin. Code.

If the procedure can be described and its medical necessity explained in a few words, providers may use Element 19 ("Reserved for Local Use") of the CMS 1500 claim form. If this space is not sufficient, write "see attached" in Element19 and attach additional documentation to the claim.

New laboratory tests that have not received a CPT or Health Care Procedure Coding System, formerly known as "HCFA Common Procedure Coding System," procedure code should be billed as an unlisted procedure. Wisconsin Medicaid commonly reimburses only tests that are approved by the federal Food and Drug Administration (FDA).

Laboratory Test Preparation and Handling Fees

If a physician obtains a specimen and forwards it to an outside laboratory, only the outside laboratory that performs the procedure may be

If a physician obtains a specimen and forwards it to an outside laboratory, only the outside laboratory that performs the procedure may be paid for the procedure.

paid for the procedure. The physician who forwards the specimen is only reimbursed a handling fee.

Preparation and handling fees for forwarding a specimen from a physician's office to an outside laboratory is billed using procedure code 99000 (TOS "5"). Procedure code 99001 (TOS "5") is used to bill for forwarding a specimen from someplace other than a physician's office to a laboratory. It is not necessary to indicate on the claim form the specific laboratory test performed.

A handling fee is not reimbursable if the physician is reimbursed for the professional and/or technical component of the laboratory test.

Wisconsin Medicaid reimburses physicians in the hospital setting, inpatient or outpatient, for the professional component only for those procedure codes listed with TOS "X" in Appendix 1 of this section.

Additional Limitations

Additional limitations on billing handling fees are:

1. One laboratory handling fee is reimbursed to a physician per recipient, per outside laboratory, per date of service (DOS), regardless of the number of specimens sent to the laboratory.
2. More than one handling fee is reimbursed when specimens are sent to two or more laboratories for one recipient on the same DOS. Indicate the number of laboratories in the units field in Element 24G and the total charges in Element 24F of the CMS 1500 claim form. The name of the laboratory does not need to be indicated on the claim form; however, this information must be documented in the records.
3. A laboratory handling fee is reimbursed only when "yes" is indicated for outside laboratory in Element 20 of the CMS 1500 claim form.
4. The DOS must be the date the specimen is obtained, not sent.

Hospital-Based Laboratory Services

Wisconsin Medicaid reimburses physicians in the hospital setting, inpatient or outpatient, for the professional component only for those procedure codes listed with TOS "X" in Appendix 1 of this section. A written report of the analysis and interpretation of the laboratory test results, which must be maintained in the recipient's medical record, is required for reimbursement of the professional component.

The technical component is paid to the hospital according to the hospital's usual Medicaid reimbursement method. Pathologists or other physicians who perform the professional component must be separately certified and claims for the professional component must be submitted on the CMS 1500 claim form or its electronic equivalent.

Newborn Screenings

Providers are required to test newborns for certain congenital and metabolic disorders, per s. 253.13, Wis. Stats. These tests require a pre-paid filter paper card purchased from the State Laboratory of Hygiene. Wisconsin Medicaid reimburses providers for purchasing the pre-paid filter paper cards and the laboratory handling fee for newborn screenings performed outside a hospital setting.

Coverage and Reimbursement Procedures

The following is a list of the CPT codes with allowable POS and/or TOS and instructions for submitting claims to Wisconsin Medicaid for Medicaid-covered newborn screening services.

- *86849* — Unlisted immunology procedure.
  - ✓ Wisconsin Medicaid reimburses this procedure code for prepaid filter paper cards purchased from the State Laboratory of Hygiene.
  - ✓ This procedure code is allowable in POS "3" (doctor's office) or POS "4" (home) for TOS "5" (diagnostic laboratory — total charge).
  - ✓ In Element 19 of the CMS 1500 claim form enter "Newborn screening state lab card" or attach documentation to a paper claim to

indicate the claim is for a prepaid filter paper card for newborn screening purchased from the Wisconsin State Laboratory of Hygiene.

- *99000* — Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory.
  - ✓ Wisconsin Medicaid reimburses this procedure code for the transfer of the specimen from the physician's office to the State Laboratory of Hygiene.
  - ✓ Physicians and nurse practitioners use TOS "5" (diagnostic lab — total charge) and certified nurse midwives who are not certified as nurse practitioners use TOS "9" (other) for this procedure code.
  - ✓ Physicians and nurse practitioners must check the "outside lab" box "Yes" (Element 20 of the CMS 1500 claim form).
  - ✓ Indicate a quantity of 1.0 since the specimen is going to only one lab.

- *99001* — Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory.
  - ✓ Wisconsin Medicaid covers this procedure code for the transfer of the specimen from a location other than a physician's office to the State Laboratory of Hygiene.
  - ✓ Physicians and nurse practitioners use TOS "5" (diagnostic lab — total charge) and certified nurse midwives who are not certified as nurse practitioners use TOS "9" (other) for this procedure code.
  - ✓ Physicians and nurse practitioners must check the "outside lab" box "Yes" (Element 20 of the CMS 1500 claim form).
  - ✓ Indicate a quantity of 1.0 since the specimen is going to only one lab.

Routine Venipuncture

Routine venipuncture is not separately reimbursable, but is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee. The recipient may not be billed for routine venipuncture.

R Routine venipuncture is not separately reimbursable, but is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee.

Noncovered Laboratory Services

Laboratory services that are not medically necessary are not covered services under Wisconsin Medicaid. This includes, but is not limited to, the following services:

- Services to enhance the prospects of fertility.
- Services that are experimental in nature.
- Services that do not have FDA or DHCF approval.

Radiology Services

Reimbursement for Radiologic Services

Wisconsin Medicaid reimburses only for those radiologic services (i.e., diagnostic imaging, therapeutic radiology, and nuclear medicine services) actually performed by or under the professional supervision of the physician.

Wisconsin Medicaid reimburses separately for diagnostic imaging agents (e.g., low osmolar contrast material), radiopharmaceutical diagnostic agents (e.g., technetium), and other contrast media used in conjunction with radiological services. Wisconsin Medicaid does not separately reimburse the venipuncture associated with administration of these materials.

Radiologic Procedures

Wisconsin Medicaid coverage of diagnostic imaging, therapeutic radiology, and nuclear medicine services is based on the procedure performed and is identified by the *Current Procedural Terminology* (CPT) code which best describes that procedure.

Medicaid-Allowable Procedure Codes

Wisconsin Medicaid coverage of diagnostic imaging, therapeutic radiology, and nuclear medicine services is based on the procedure performed and is identified by the *Current Procedural Terminology* (CPT) code which best describes that procedure. Wisconsin Medicaid does not allow reimbursement for all CPT codes (e.g., fertility-related services are not covered). Refer to Appendix 4 of this section for Wisconsin Medicaid-allowable radiology procedure codes and their appropriate type of service (TOS) and place of service (POS) codes.

Complete Radiologic Procedure vs. Professional and Technical Components

A physician or physician clinic may be reimbursed for the "complete" (total) procedure (TOS "4," "6," or "K," as appropriate) when performing both the professional and technical components, or supervising others who do so in the office, clinic, or other nonhospital setting. Radiologic procedure codes also have technical and professional components that are separately reimbursable. Refer to Appendix 4 of this section for the appropriate procedure code and TOS code combinations.

A ***written report*** regarding the analysis and interpretation of the radiologic test results is required for Wisconsin Medicaid reimbursement of the professional component. The written report must be kept as part of the recipient's medical record.

If the POS is a hospital setting (inpatient, POS "1," or outpatient, POS "2"), or if the technical portion is performed by a portable X-ray provider, a physician may be reimbursed only for the professional component, not for the complete procedure. The technical component is reimbursed to the hospital or provider of portable X-ray services.

Physician clinics that perform only the technical component of radiologic services are reimbursed by Wisconsin Medicaid only for the technical component. The outside physician performing the professional component of the service is reimbursed only for the professional component.

The attending physician's clinical interpretation of radiology services is not separately reimbursed because it is included in Wisconsin Medicaid's reimbursement for the physician-patient encounter (i.e., the evaluation and management service).

Unlisted Procedures

Medicaid claims for an unlisted (nonspecific) procedure code require documentation describing the procedure performed. If the

procedure can be described in a few words, write the description in Element 19 ("Reserved for Local Use") of the CMS 1500 claim form.

If this space is not sufficient, write "see attached" in Element 19 and attach additional documentation describing in detail the procedure or service. The documentation must also be sufficient to allow the chief medical officer to determine the nature and scope of the procedure and whether the procedure was medically necessary as defined in the Wisconsin Administrative Code.

Consultations

Wisconsin Medicaid reimburses physicians for radiology consultations (TOS "3") only when medically necessary and appropriate for the recipient's treatment. Radiology consultations are reimbursable only when performed at the request of the attending physician and the results are contained in a written report, which is maintained in the recipient's medical record.

Radiological Supervision and Interpretation by Providers Who Are Not Radiologists

Radiological supervision and interpretation services are provided nearly exclusively by radiologists. Providers who are not radiologists are urged to use caution in billing such services to avoid duplicate billing with radiologists.

Radiological supervision and interpretation services are provided nearly exclusively by radiologists.

Hospital-Based Radiology Services

Wisconsin Medicaid reimburses hospitals for the technical component of a radiology service. The professional component is not included in the hospital's reimbursement. Therefore, physicians with a specialty of radiology or nuclear medicine must be separately certified, and claims for the professional component must be submitted on the CMS 1500 claim form or its electronic equivalent.

B Billing and Reimbursement

Claims Submission Deadline

Wisconsin Medicaid must receive properly completed claims for services provided to eligible Medicaid recipients within 365 days from the date the service was provided. This policy applies to all initial claims submissions, resubmissions, and adjustment requests.

A All claims that providers submit, whether electronic or paper, are subject to the same Medicaid processing and legal requirements.

Exceptions to the 365-day claims submission deadline and requirements for submission to Late Billing Appeals can be found in the Claims Submission section of the All-Provider Handbook. Providers may obtain copies of the handbook at *www.dhfs.state.wi.us/medicaid/* or by calling Provider Services at (800) 947-9627 or (608) 221-9883.

Electronic Billing

Wisconsin Medicaid processes claims that providers submit on magnetic tape (tape-to-tape) or via modem. All claims that providers submit, whether electronic or paper, are subject to the same Medicaid processing and legal requirements. Providers usually reduce their claim errors when they submit claims electronically.

Wisconsin Medicaid provides software for billing electronically. If interested in billing electronically, please call the Electronic Media Claims (EMC) Department at (608) 221-4746 and ask to speak with an EMC coordinator, to request the appropriate information. For technical questions about the EZ-Link software, please call (800) 822-8050.

All physician laboratory and radiology services may be billed electronically except when billing an "unlisted" (nonspecific) procedure code. A claim for an unlisted procedure code must be submitted on the paper CMS 1500 claim form with a description of the procedure written in Element19 of the claim or written on a separate document attached to the claim.

CMS 1500 Claim Form

Physicians submitting paper claims must use the CMS 1500 claim form dated 12/90. Wisconsin Medicaid denies claims for physician services submitted on any paper claim form other than the CMS 1500 claim form. Refer to Appendix 5 of this section for CMS 1500 claim form completion instructions.

Wisconsin Medicaid does not provide the CMS 1500 claim form. The form may be obtained from any federal form supplier.

Where to Send Your Claims

Mail completed CMS 1500 claim forms for reimbursement to the following address:

Wisconsin Medicaid
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Billed Amounts

Providers are to submit claims to Wisconsin Medicaid with their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits. For providers using a sliding fee scale for specific services, the usual and customary charge is the median (i.e., 50% of charges are above and 50% are below) of the individual providers' charge for the service when provided to non-Medicaid patients.

Under s. 49.43(1m), Wis. Stats., "charge" means "the customary, usual and reasonable demand for payment as established

prospectively, concurrently or retrospectively," which may not "exceed the general level of charges by others who render such service or care, or provide such commodities, under similar or comparable circumstances within the community in which the charge is incurred."

For providers who have not established usual and customary charges, Medicaid charges should be reasonably related to the provider's cost to provide the services.

Terms of Reimbursement Agreement

As part of Wisconsin Medicaid certification, providers sign an agreement to:

- Bill Wisconsin Medicaid in accordance with Wisconsin Medicaid requirements, including billing usual and customary charges by most providers.
- Accept Wisconsin Medicaid's Terms of Reimbursement, as defined in their Wisconsin Medicaid certification packet.

Reimbursement

Maximum Allowable Fees

The maximum allowable fee is the maximum amount that Wisconsin Medicaid will pay a provider for an allowable procedure code. (Wisconsin Medicaid reimburses providers the lesser of the billed amount and the maximum allowable fee for the procedure.) Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted to Wisconsin Medicaid, the Wisconsin State Legislature's budgetary constraints, and other relevant economic limitations.

Wisconsin Medicaid sets the maximum allowable fee for each laboratory and radiology service equal to or less than the amount allowed by Medicare as required by the federal Deficit Reduction Act (Section 2303 of the federal Deficit Reduction Act [DEFRA — P.L. 98-369]).

Providers are encouraged to obtain a schedule of Wisconsin Medicaid maximum allowable fees for physician services from one of the following sources:

- An electronic version on Wisconsin Medicaid's Web site at *www.dhfs.state.wi.us/medicaid/*.
- Purchase a paper copy by writing to:

  Wisconsin Medicaid
  Provider Maintenance
  6406 Bridge Rd
  Madison WI 53784-0006

  Call Provider Services at (800) 947-9627 or (608) 221-9883 for the cost of the fee schedule.

Maximum Daily Reimbursement

A provider's reimbursement for all services performed on the same date of service for the same recipient may not exceed the amount established by Wisconsin Medicaid, except for services lasting over six hours. As of July 1, 2002, the maximum amount is $2,308.43. Provider reimbursement potentially exceeding this amount is limited to the maximum amount and a message appears on the Remittance and Status (R/S) Report informing the provider of the limit.

A service exceeding six hours must first be billed to Wisconsin Medicaid in the usual manner. After the reimbursement is received, additional reimbursement may be requested by submitting an Adjustment Request Form ***with clinical documentation*** to Wisconsin Medicaid. Refer to the Claims Submission section of the All-Provider Handbook for a sample Adjustment Request Form and instructions.

Wisconsin Medicaid sets the maximum allowable fee for each laboratory and radiology service equal to or less than the amount allowed by Medicare as required by the federal Deficit Reduction Act (Section 2303 of the federal Deficit Reduction Act [DEFRA — P.L. 98-369]).

Medicaid Payment

Wisconsin Medicaid reimburses fee-for-service providers the lesser of the following:

1. Medicaid's maximum allowable fee for the service.
2. The provider's billed amount.

Monitoring Medicaid Policy

Wisconsin Medicaid monitors claims for compliance with Medicaid reimbursement policy using an automated procedure coding review software known as McKesson ClaimCheck®. This software reviews claims submitted to Wisconsin Medicaid for billing inconsistencies and errors with respect to *Current Procedural Terminology* (CPT) codes.

ClaimCheck review may affect claims in one of the following ways:

1. The claim is unchanged by the review.
2. The procedure codes are rebundled into one or more appropriate codes.
3. One or more of the codes is denied as incidental/integral or mutually exclusive.

Wisconsin Medicaid monitors claims for compliance with Medicaid reimbursement policy using an automated procedure coding review software known as McKesson ClaimCheck®.

ClaimCheck monitors the following Medicaid policy areas:

1. *Unbundling (Code Splitting)*
   Unbundling occurs when two or more CPT codes are used to describe a procedure that may be better described by a single, more comprehensive code. ClaimCheck considers the single, most appropriate code for reimbursement when unbundling is detected.

   For example, if you bill certain laboratory tests separately, ClaimCheck rebundles them into the single, most appropriate panel (e.g., obstetric panel — [80055] or hepatic function panel — [80076]).

   ClaimCheck totals billed amounts for individual procedures. For example, if you bill three procedures at $20, $30, and $25, ClaimCheck rebundles them into a single procedure code, adds the three amounts, and calculates the billed amount for that rebundled code at $75. However, Wisconsin Medicaid reimburses you either the lesser of the billed amount or the maximum allowable fee for that procedure code.

2. *Incidental/Integral Procedures*
   Incidental/integral procedures are those procedures performed as part of or at the same time as a more complex primary procedure. They require few additional physician resources and are generally not considered necessary to the performance of the primary procedure. For example, a radiologic examination, spine, single view, specify level (procedure code 72020) is incidental to a radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies (procedure code 72052).

   When a procedure is either incidental or integral to a major procedure, ClaimCheck considers only the *primary* procedure for reimbursement.

3. *Mutually Exclusive Procedures*
   Mutually exclusive procedures are procedures that would not be performed on a single recipient during the same operative session or that use different codes to describe the same type of procedure. For example, a radiologic examination, shoulder; one view (procedure code 73020) and radiologic examination, shoulder; complete, minimum of two views (procedure code 73030) are mutually exclusive — either one or the other, but not both procedures are performed.

When two or more procedures are mutually exclusive, Wisconsin Medicaid reimburses the procedure code with the highest provider-billed amount.

Why Was Payment for a Service Denied by ClaimCheck?

Follow these procedures if you are uncertain about why particular services on a claim were denied:

1. Review the Explanation of Benefits denial code included on the R/S Report for the specific reason for the denial.
2. Review the claim submitted to ensure all information is accurate and complete.
3. Consult current CPT publications to make sure proper coding instructions were followed.
4. Consult this handbook section and other current Wisconsin Medicaid publications to make sure current policy and billing instructions were followed.
5. Contact Medicaid Provider Services at (800) 947-9627 or (608) 221-9883 for further information or explanation.
6. If circumstances warrant an exception, submit an Adjustment Request Form with supporting documentation and the words "medical consultant review requested" written on the form.

Abortions, Hysterectomies, and Sterilizations

Wisconsin Medicaid requires surgeons to attach specific documentation to their claim when billing for an abortion, a hysterectomy, or a sterilization procedure. If the surgeon does not attach the required documentation, the surgeon's claim and ***all*** other claims directly related to the surgery are denied reimbursement. This includes a physician's laboratory or radiology claim. Therefore, verify with the surgeon's office that the surgeon has obtained the necessary documentation ***before*** the surgery is performed.

For more information about Wisconsin Medicaid's requirements for reimbursing abortion, hysterectomy, and sterilization claims, refer to the Medicine and Surgery section of the Physician Services Handbook.

Follow-Up to Claims Submission

Providers, not Wisconsin Medicaid, initiate follow-up procedures on Medicaid claims. Processed claims appear on the R/S Report either as paid, pending, or denied. Wisconsin Medicaid takes no further action on a denied claim unless the provider corrects the information and resubmits the claim for processing.

If a claim is paid incorrectly, the provider must submit an Adjustment Request Form to Wisconsin Medicaid. The Claims Submission section of the All-Provider Handbook includes detailed information regarding:

- The R/S Report.
- Adjustments to paid claims.
- Overpayments.

Providers, not Wisconsin Medicaid, initiate follow-up procedures on Medicaid claims.

Appendix

Appendix 1

Wisconsin Medicaid-Allowable Procedure Codes, Type of Service Codes, and Place of Service Codes for Physician Laboratory Services

Some procedure codes within the ranges below may not be covered by Wisconsin Medicaid. Consult the Physician Services Maximum Allowable Fee Schedule or call Provider Services at (800) 947-9627 or (608) 221-9883, regarding coverage of specific procedure and type of service (TOS) code combinations. The chart below is periodically revised. Refer to the other sections of the Physician Services Handbook for anesthesia, evaluation and management, medicine, and surgery procedure codes.

Service	*Current Procedural Terminology* (CPT) Procedure Codes	TOS
Pathology and Laboratory Services		
Organ or Disease Oriented Panels	80048-80090	5
Drug Testing	80100-80103	5
Therapeutic Drug Assays	80150-80299	5
Evocative/ Suppression Testing	80400-80440	5
Consultations	80500-80502	3
Urinalysis	81000-81099	5
Chemistry	82000-83018	5
	83020-83021	5, U, X
	83026-83690	5
	83715-83716	5, U, X
	83718-83785	5
	83788-83789	5, U, X
	83805-83906	5
	83912	X
	83915-84160	5
	84165-84182	5, U, X
	84202-84999	5
Hematology and Coagulation	85002-85048	5
	85060-85097	5, U, X
	85130-85385	5
	85390	5, U, X
	85400-85557	5
	85576	5, U, X
	85585-85999	5

Appendix 1
(Continued)

Service	CPT Procedure Codes	TOS
Pathology and Laboratory Services (Continued)		
Immunology	86000-86243	5
	86255-86256	5, U, X
	86277-86318	5
	86320-86334	5, U, X
	86336-86849	5
Transfusion Medicine	86850-86999	5
Microbiology	87001-87158	5
	87164-87166	5, U, X
	87168-87206	5
	87207	5, U, X
	87210-87904	5
	87999	5, U, X
Cytopathology	88104-88125	5, U, X
	88130-88140	5
	88141	X
	88142-88155	5
	88160-88162	5, U, X
	88164-88167	5
	88172-88199	5, U, X
Cytogenetic Studies	88230-88289	5
	88291	X
	88299	5, U, X
Surgical Pathology	88300-88319	5, U, X
	88321-88329	3
	88331-88399	5, U, X
Transcutaneous Procedures	88400	5
Other Procedures	89050-89261	5
	89264	5, U, X
	89300-89321, 89350, 89360-89365	5
	89399	5, U, X
Laboratory Handling Fees	99000-99001	5

Appendix 1
(Continued)

Service	Health Care Procedure Coding System* Procedure Codes	TOS
Pathology and Laboratory Services (Continued)		
Procedures/ Professional Services	G0026-G0027, G0103, G0107, G0123-G0124, G0141-G0148	5
Pathology and Laboratory	P2028-P3001, P9010-P9044	5
	P9045-P9050	1
	P9615	5
Temporary Codes	Q0091, Q0111-Q0115	5
Private Payer Codes	S3645-S3650	5
	S3708	5, U, X

*Formerly known as "HCFA Common Procedure Coding System."

TOS	Description
1	Medical care, injections, HealthCheck (EPSDT)
3	Consultations
5	Diagnostic Lab (total charge) HealthCheck Lab
U	Diagnostic testing, diagnostic medical services — technical component only
X	Diagnostic laboratory — professional component only (interpretation), generally used by pathologists

Place of Service	Description
0	Other
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility

Appendix 2

Wisconsin Medicaid-Allowable CLIA Waiver Certificate Procedure Codes

The Medicaid-allowable Clinical Laboratory Improvement Amendment (CLIA) waiver certificate procedure codes may change due to CLIA or *Current Procedural Terminology* changes. Refer to the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, Web site at *www.cms.hhs.gov/clia/waivetbl.pdf* for more information.

Procedure Code	Modifier	Procedure Description	CLIA-Allowable Manufacturer of Tests for Waived Procedures
80061	QW	Lipid panel	Cholestech
80101	QW	Drug screen, qualitative; single drug class method (eg, immunoassay, enzyme assay), each drug class	Dynagen, Inc.; Pharmatech; Worldwide Medical Corporation
81002		Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy	various
81003	QW	automated, without microscopy	Bayer Corp.; Boehringer Mannheim Corp.; Roche Diagnostics/Boehringer Mannheim Corp.; Teco Diagnostics
81007	QW	Urinalysis; bacteriuria screen, except by culture or dipstick	Savyon/USA
81025		Urine pregnancy test, by visual color comparison methods	various
82010	QW	Acetone or other ketone bodies, serum; quantitative	Abbott Laboratories, Inc.; Polymer Technology Systems, Inc.
82044	QW	Albumin; urine, microalbumin, semiquantitative (eg, reagent strip assay)	Bayer Corp.; Boehringer Mannheim Corp.; Roche Diagnostics Corp.
82055	QW	Alcohol (ethanol); any specimen except breath	OraSure Technologies, Inc.; STC Technologies, Inc.
82120	QW	Amines, vaginal fluid, qualitative	Litmus Concepts, Inc.
82270		Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, 1-3 simultaneous determinations	various
82273	QW	other sources	SmithKline Diagnostics, Inc.
82274	QW	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations	Enterix

Appendix 2
(Continued)

Procedure Code	Modifier	Procedure Description	CLIA-Allowable Manufacturer of Tests for Waived Procedures
82465	QW	Cholesterol, serum or whole blood, total	ActiMed Laboratories, Inc.; Boehringer Mannheim Corp.; Chemtrak; Cholestech; Johnson & Johnson; Lifestream Technologies; Polymer Technology Systems, Inc.
82523	QW	Collagen cross links, any method	Ostex International, Inc.
82570	QW	Creatinine; other source	Bayer Corp.
82679	QW	Estrone	Unipath Limited
82947	QW	Glucose; quantitative, blood (except reagent strip)	Cholestech; HemoCue
82950	QW	post glucose dose (includes glucose)	Cholestech; HemoCue
82951	QW	tolerance test (GTT), three specimens (includes glucose)	Cholestech; HemoCue
82952	QW	tolerance test, each additional beyond three specimens	Cholestech; HemoCue
82962		Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use	Abbott Laboratories, Inc.; LXN Corporation; various
82985	QW	Glycated protein	LXN Corporation
83001	QW	Gonadotropin; follicle stimulating hormone (FSH)	Genua 1944 Inc.
83002	QW	luteinizing hormone (LH)	Unipath Limited
83026		Hemoglobin; by copper sulfate method, non-automated	various
83036	QW	glycated	Bayer Corp.; Metrika, Inc.
83518	QW	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; single step method (eg, reagent strip)	Bion Diagnostic Sciences, Inc.
83718	QW	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)	Cholestech; Polymer Technology Systems, Inc.
83986	QW	pH, body fluid, except blood	various
84460	QW	Transferase; alanine amino (ALT) (SGPT)	Cholestech Corporation
84478	QW	Triglycerides	Cholestech; Polymer Technology Systems, Inc.

Appendix 2
(Continued)

Procedure Code	Modifier	Procedure Description	CLIA-Allowable Manufacturer of Tests for Waived Procedures
84703	QW	Gonadotropin, chorionic (hCG); qualitative	Bayer Corp.
84830		Ovulation tests, by visual color comparison methods for human luteinizing hormone	various; Litmus Concepts, Inc.
85013		Blood count; spun microhematocrit	various
85014	QW	hematocrit (Hct)	Wampole Laboratories
85018	QW	hemoglobin (Hgb)	GDS Technology, Inc.; HemoCue
85610	QW	Prothrombin time;	Avocet Medical, Inc.; Boehringer Mannheim Corp.; International Technidyne Corp.; Roche Diagnostics Corp.; Roche Diagnostics/Boehringer Mannheim Corp.
85651		Sedimentation rate, erythrocyte; non-automated	various
86294	QW	Immunoassay for tumor antigen, qualitative or semiquantitative (eg, bladder tumor antigen)	Bion Diagnostic Sciences, Inc.
86308	QW	Heterophile antibodies; screening	Applied Biotech, Inc.; Genzyme Diagnostics; Princeton BioMeditech Corp.; Quidel Corporation; Wampole Laboratories; Wyntek Diagnostics, Inc.
86318	QW	Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (eg, reagent strip)	Abbott Laboratories; Applied Biotech, Inc.; Cortecs Diagnostics Limited; Princeton BioMeditech; Quidel Corp.; Remel; SmithKline Diagnostics, Inc.; Trinity BioTech
86618	QW	Antibody; Borrelia burgdorferi (Lyme disease)	Wampole Laboratories
87077	QW	Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate	Ballard Medical Products; Delta West Tri-Med Specialties; Mycoscience Labs, Inc.; Serim
87449	QW	Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple step method, not otherwise specified, each organism	Zymetx, Inc.
87804	QW	Infectious agent detection by immunoassay with direct optical observation; Influenza	Quidel Corp.

Appendix 2
(Continued)

Procedure Code	Modifier	Procedure Description	CLIA-Allowable Manufacturer of Tests for Waived Procedures
87880	QW	Infectious agent detection by immunoassay with direct optical observation; Streptococcus, group A	Applied Biotech, Inc.; Binax; Genzyme Diagnostics; Princeton BioMeditech; Quidel Corp.; Wyntek Diagnostics, Inc.
87899	QW	not otherwise specified	Quidel Corp.
89300	QW	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)	Embryotech Laboratories, Inc.

Appendix 3

Wisconsin Medicaid-Allowable CLIA Provider-Performed Microscopy Procedure Codes

The Medicaid-allowable Clinical Laboratory Improvement Amendment (CLIA) provider-performed microscopy procedure codes may change due to CLIA, *Current Procedural Terminology* (CPT), or Health Care Procedure Coding System (HCPCS) code changes. Refer to the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, Web site at *www.cms.hhs.gov/clia/ppmplst.asp* for more information.

CPT Codes	
Procedure Code	**Procedure Description**
81000	Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	automated, with microscopy
81015	Urinalysis; microscopic only
81020	two or three glass test
89190	Nasal smear for eosinophils

Health Care Procedure Coding System* Codes	
Procedure Code	**Procedure Description**
G0026	Fecal leucocyte examination
G0027	Semen analysis; presence and/or motility of sperm excluding Huhner
Q0111	Wet mounts, including preparations of vaginal, cervical or skin specimens
Q0112	All potassium hydroxide (koh) preparations
Q0113	Pinworm examinations
Q0114	Fern test
Q0115	Post-coital direct, qualitative examinations of vaginal or cervical mucous

*Formerly HCFA Common Procedure Coding System

Appendix 4

Wisconsin Medicaid-Allowable Procedure Codes, Type of Service Codes, and Place of Service Codes for Physician Radiology Services

Some procedure codes within ranges below may not be covered by Wisconsin Medicaid. Consult the Physician Services Maximum Allowable Fee Schedule or call Provider Services at (800) 947-9627 or (608) 221-9883 regarding coverage of specific procedure and type of service (TOS) code combinations. The chart below is periodically revised. Refer to the other sections of the Physician Services Handbook for anesthesia, evaluation and management, medicine, and surgery procedure codes.

Service	*Current Procedural Terminology* Procedure Codes	TOS
Radiology Services		
Diagnostic Radiology (Diagnostic Imaging)	70010-75946	4, Q, U
	75952-75953	Q
	75960-76010	4, Q, U
	76012-76013	Q
	76020-76125	4, Q, U
	76140	3
	76150-76400	4, Q, U
Diagnostic Ultrasound	76490-76999	4, Q, U
Radiation Oncology	77261-77263	S
	77280-77334	6, S, U
	77336-77370	3
	77399	6, S, U
	77401-77418	U
	77427-77432	S
	77470-77799	6, S, U
Nuclear Medicine	78000-78891	K, T, U
	78990	U
	78999-79440	K, T, U
	79900	U
	79999	K, T, U

Service	Health Care Procedure Coding System* (HCPCS) Procedure Codes	TOS
Radiology Services (Continued)		
Radiopharmaceutical Contrast Media	A4641, A4644-A4647, A9500-A9505, A9508-A9510, A9600, A9700	9
Procedures/ Professional Services	G0030-G0047	Q
	G0050	4, Q, U
	G0125-G0132	4, Q, U
	G0173	6, S, U
	G0204-G0206	4, Q, U
	G0210-G0234	Q
	G0236	4, Q, U
	G0242-G0243	6, S, U
Radiopharmaceutical Temporary Codes	Q3001-Q3012	9
Private Payer Codes	S0830	4
	S8030	6, S, U
	S8035-S8040	4, Q, U
	S8049	6, S, U
	S8080	K, T, U
	S8085-S8092, S9022, S9024	4, Q, U

*Formerly known as "HCFA Common Procedure Coding System."

TOS	Description
3	Consultations
4	Diagnostic radiology, total or complete procedure, including professional and technical components
6	Therapeutic radiology (radiation therapy) — total or complete procedure, including professional and technical components
K	Nuclear medicine — total or complete, including professional and technical components
Q	Diagnostic radiology — professional component (interpretation) only
S	Therapeutic radiology (radiation therapy) — professional component only
T	Nuclear medicine — professional component (interpretation) only
U	Diagnostic radiology — technical component only

Place of Service	Description
0	Other
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
7	Nursing Home
8	Skilled Nursing Facility

Appendix 5

CMS 1500 Claim Form Completion Instructions

Use the following claim form completion instructions, ***not*** the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Do not include attachments unless instructed to do so. Complete the elements listed below as appropriate. No other elements are required.

Note: Medicaid providers should ***always*** verify recipient eligibility before rendering services.

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify if male or female with an "X."

Mother/Baby Claims

A provider may submit claims for an infant if the infant is 10 days old or less on the date of service (DOS) and the mother of the infant is a Medicaid recipient. To bill for an infant using the mother's Medicaid identification number, enter the following:

Element 1a: Enter the mother's 10-digit Medicaid identification number.

Element 2: Enter the mother's last name followed by "newborn."

Element 3: Enter the ***infant's*** date of birth.

Element 4: Enter the mother's name followed by "mom" in parentheses.

Element 21: Indicate the secondary or lesser diagnosis code "M11" in fields 2, 3, or 4.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

Commercial insurance (private insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service is not covered by insurance as determined by Wisconsin Medicaid.

- When the recipient has dental (DEN) insurance only or has no commercial insurance, leave Element 9 blank.
- When the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), TriCare ("CHA"), or some other ("OTH") commercial insurance, ***and*** the service requires other health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes ***must*** be indicated in the ***first*** box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by health insurance. In Element 29 of this claim form, indicate the amount paid by health insurance to the provider or to the insured.
OI-D	DENIED by health insurance following submission of a correct and complete claim, ***or*** payment was applied towards the coinsurance and deductible. Do ***not*** use this code unless the claim was actually billed to the health insurer.
OI-Y	YES, The recipient has health insurance, but it was not billed for reasons including, but not limited to: ✓ Recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ Health insurance failed to respond to initial and follow-up claims. ✓ Benefits not assignable or cannot get assignment.

- When the recipient is a member of a commercial HMO, one of the following must be indicated, ***if applicable:***

Code	Description
OI-P	PAID by HMO. The amount paid is indicated on the claim.
OI-H	HMO does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note*:* The provider may not use OI-H if the commercial HMO denied payment because an otherwise covered service was not provided by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number

Use the ***first*** box of this Element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Bill Medicare before billing Wisconsin Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- The recipient's Wisconsin Medicaid file shows he or she does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A. Services related to a diagnosis of chronic renal failure are the only exceptions.
- The ***non-physician*** provider's Wisconsin Medicaid file shows he or she is not Medicare certified. (This does not apply to physicians because Medicare will retroactively certify physicians for the date and the service provided if they held a valid license when the service was performed.)
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

Appendix 5
(Continued)

If none of the previous statements are true, a Medicare disclaimer code is necessary.

The following Medicare disclaimer codes can be used when appropriate:

Code	Description
M-1	**Medicare benefits exhausted.** This code can be used when Medicare has denied the charges because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use the M-1 disclaimer in these two instances only: *For Medicare Part A* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. • The recipient is eligible for Medicare Part A. • The service provided is covered by Medicare Part A but is not payable due to benefits being exhausted. *For Medicare Part B* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. • The recipient is eligible for Medicare Part B. • The service provided is covered by Medicare Part B but is not payable due to benefits being exhausted.
M-5	**Provider is not Medicare certified.** *(This code is not applicable to physicians)* This code can be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for DOS before or after their Medicare certification effective dates. Use M-5 in these two instances only: *For Medicare Part A* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A but not for the date the service was provided. • The recipient is eligible for Medicare Part A. • The procedure provided is covered by Medicare Part A. *For Medicare Part B* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B but not for the date the service was provided. • The recipient is eligible for Medicare Part B. • The procedure provided is covered by Medicare Part B.

Appendix 5
(Continued)

M-6 **Recipient not Medicare eligible.** This code can be used when Medicare denies payment for services related to ***chronic renal failure*** (diagnosis code "585") because the recipient is not eligible for Medicare. Medicare must be billed first, even when the recipient is identified in Wisconsin Medicaid files as not eligible for Medicare. Use the M-6 disclaimer code in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

M-7 **Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy, not billing errors. Use M-7 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, etc.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, etc.

M-8 **Noncovered Medicare service.** This code can be used when Medicare was not billed because the service, under certain circumstances related to the recipient's diagnosis, is not covered. Use M-8 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A but not under certain circumstances related to the recipient's diagnosis.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not under certain circumstances related to the recipient's diagnosis.

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Element 17 — Name of Referring Physician or Other Source

Required for nonemergency services. Enter the referring or prescribing physician's name.

Element 17a — I.D. Number of Referring Physician

Enter the referring physician's six-character Universal Provider Identification Number (UPIN) number. If the UPIN number is not available, enter the eight-digit Medicaid provider number or license number of the referring physician.

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use

If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be given in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate "See Attachment" in Element 19. Unlisted procedure codes are required to be submitted through paper claims submission. Do not bill unlisted procedure codes through electronic billing.

Element 20 — Outside Lab?

If a laboratory handling fee is billed, check "yes" to indicate that the specimen was sent to an outside lab. Otherwise, this element is not required.

Element 21 — Diagnosis or Nature of Illness or Injury

Enter either the general code (V72.5 for radiological exams and V72.6 for laboratory exams) or other *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. Wisconsin Medicaid denies claims without the appropriate ICD-9-CM diagnosis code. The diagnosis description is not required.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required for laboratory and radiology services)

Element 24A — Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field, and subsequent DOS in the "To" field by listing ***only*** the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four DOS per line if one or all the following is applicable:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.

- All procedures have the same type of service (TOS) code.
- All procedures have the same place of service (POS) code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge ***per detail line*** in Element 24F.)
- The number of services performed on each DOS is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

Element 24B — Place of Service

Enter the appropriate Medicaid single-digit POS code for each service. Refer to Appendix 1 of this section for POS codes for laboratory services and Appendix 4 of this section for POS codes for radiology services.

Element 24C — Type of Service

Enter the appropriate Medicaid single-digit TOS code for each service. Refer to Appendix 1 of this section for appropriate procedure/TOS code combinations for laboratory services and to Appendix 4 of this section for appropriate procedure/TOS code combinations for radiology services.

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character *Current Procedural Terminology* (CPT) code, Health Care Procedure Coding System (HCPCS), formerly known as "HCFA Common Procedure Coding System," code, or local procedure code. Claims received without the appropriate CPT, HCPCS, or local code are denied by Wisconsin Medicaid.

Modifiers

Enter the Clinical Laboratory Improvement Amendment waived test modifier "QW" in the "Modifier" column of Element 24D, if appropriate. The "QW" modifier applies to certain waived laboratory tests and only to laboratories that hold a certificate of waiver. Refer to Appendix 2 of this section for a list of procedure codes that may be billed with the QW modifier. *Note:* Wisconsin Medicaid has ***not*** adopted all CPT, HCPCS, or Medicare modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F — $ Charges

Enter the total charge for each line item.

Element 24G — Days or Units

Enter the total number of services billed for each line item.

Element 24H — EPSDT/Family Plan

Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if ***both*** HealthCheck and family planning services were provided. If HealthCheck or family planning do not apply, leave this element blank.

Element 24I — EMG

Enter an "E" for ***each*** procedure performed as an emergency, regardless of the POS. If the procedure is not an emergency, leave this element blank.

Appendix 5
(Continued)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider ***for each procedure*** if the billing provider number indicated in Element 33 belongs to a physician clinic or group. If the billing provider is a group of radiologists, pathologists, a laboratory, or a portable X-ray provider, a performing provider number is not required in Element 24K.

Any other information entered in this element may cause claim denial.

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No.

Optional — provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report.

Element 27 — Accept Assignment? (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in this element, "OI-P" must be indicated in Element 9.) Do ***not*** enter Medicare-paid amounts in this field.

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

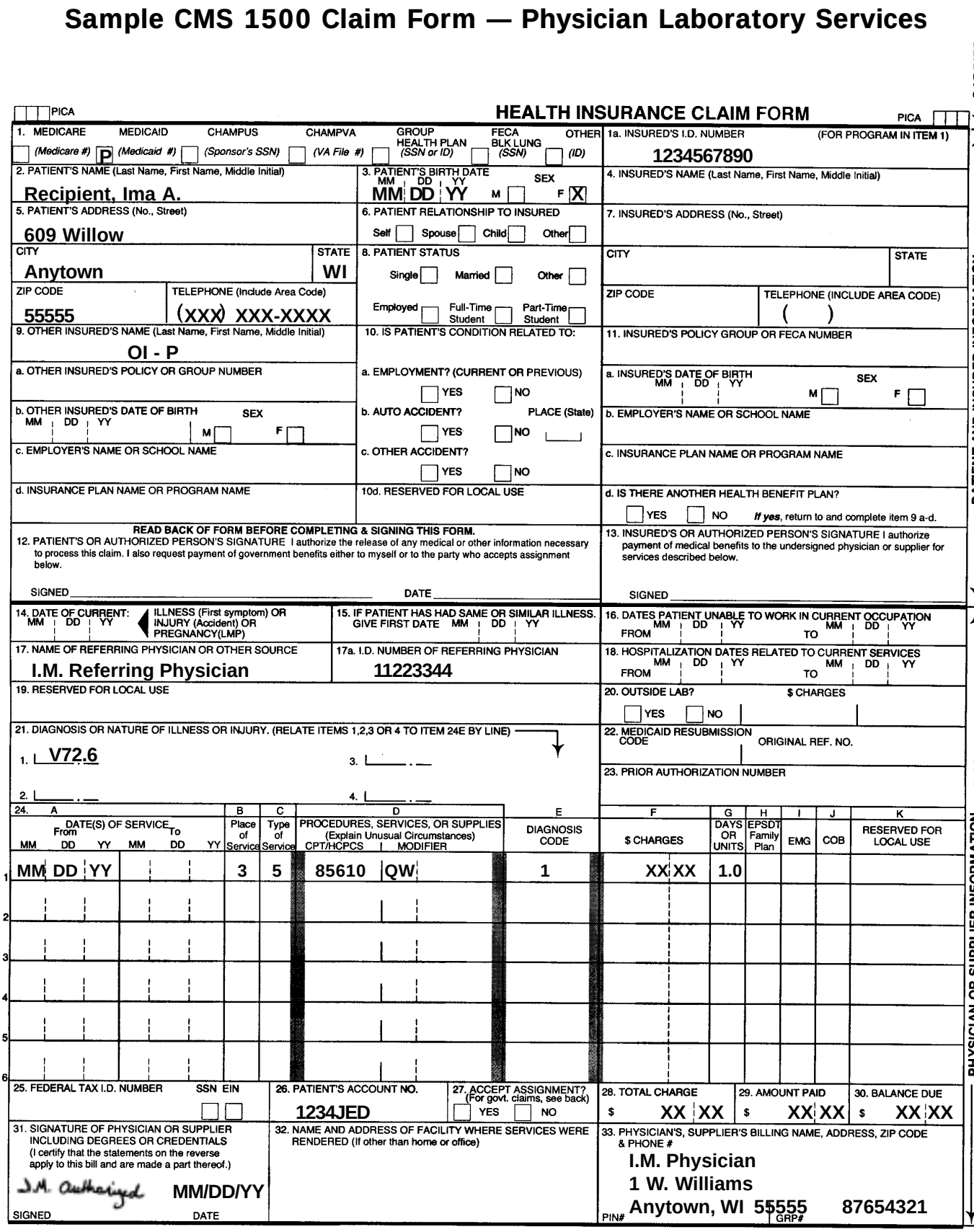
Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code and Phone

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

Appendix 6

Sample CMS 1500 Claim Form — Physician Laboratory Services



PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) P | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Ima A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI - P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring Physician

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 11223344

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V72.6 3. ____ 2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY		3	5	85610	QW	1	XX XX	1.0				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $ XX XX

29. AMOUNT PAID $ XX XX

30. BALANCE DUE $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

J.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Physician
1 W. Williams
Anytown, WI 55555

PIN# 87654321 GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Appendix

Appendix 7

Sample CMS 1500 Claim Form — Physician Radiology Services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) P | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Ima A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single | Married | Other

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed | Full-Time Student | Part-Time Student

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI - P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring Physician

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 11223344

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V72.5 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY		3	4	70100		1	XX XX	1.0				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $ XX XX

29. AMOUNT PAID $ XX XX

30. BALANCE DUE $ X XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

J.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Physician
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Appendix

Glossary of Common Terms

Adjustment

A modified or changed claim that was originally allowed, at least in part, by Wisconsin Medicaid.

Allowed claim

A Medicaid or Medicare claim that has at least one service that is reimbursable.

BadgerCare

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients' health care is administered through the same delivery system.

CMS

Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (DHHS), CMS administers Medicare, Medicaid, related quality assurance programs and other programs. Formerly known as the Health Care Financing Administration (HCFA).

Concurrent care

Evaluation and management (E&M) services provided by two or more physicians to a recipient during an inpatient hospital or nursing home stay.

CPT

Current Procedural Terminology. A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, and Wisconsin Medicaid.

Crossover Claim

A Medicare-allowed claim for a dual entitlee sent to Wisconsin Medicaid for possible additional payment of the Medicare coinsurance and deductible.

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid program that provides the Centers for Medicare and Medicaid Services (CMS), fomerly HCFA, and the U.S. Department of Health and Human Services (DHHS), assurances that the program is administered in conformity with federal law and CMS policy.

DHFS

Wisconsin Department of Health and Family Services. The DHFS administers the Wisconsin Medicaid program. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHHS

Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and

social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

DOS

Date of service. The calendar date on which a specific medical service is performed.

Dual entitlee

A recipient who is eligible for both Wisconsin Medicaid and Medicare, either Medicare Part A, Part B, or both.

ECS

Electronic Claims Submission. Claims transmitted via the telephone line and fed directly into Wisconsin Medicaid's claims processing subsystem.

Emergency services

Those services which are necessary to prevent death or serious impairment of the health of the individual. (For the Medicaid managed care definition of emergency, refer to the Managed Care Guide or the Medicaid managed care contract.)

EOB

Explanation of Benefits. Appears on the provider's Remittance and Status (R/S) Report and informs Medicaid providers of the status or action taken on their claims.

Established patient

A patient who has received professional services from the physician or from another physician of the same specialty and belonging to the same group practice, within the past three years.

EVS

Eligibility Verification System. The EVS allows providers to verify recipient eligibility prior to providing services. Providers may access recipient eligibility information through the following methods:

- Wisconsin Medicaid's Automated Voice Response (AVR) system.
- Commercial magnetic stripe card readers.
- Commercial personal computer software and Internet access.
- Wisconsin Medicaid's Provider Services (telephone correspondents).
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Fiscal agent

The Department of Health and Family Services (DHFS) contracts with Electronic Data Systems (EDS) to provide health claims processing services for Wisconsin Medicaid, including provider certification, claims payment, provider services, and recipient services. The fiscal agent also issues identification cards to recipients, publishes information for providers and recipients, and maintains the Wisconsin Medicaid Web site.

HCFA

Health Care Financing Administration. *Please see the definition under CMS.*

HCPCS

Health Care Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes *Current Procedural Terminology* (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, to supplement CPT codes. Formerly known as "HCFA Common Procedure Coding System."

HealthCheck

Program which provides Medicaid-eligible children under age 21 with regular health screenings.

HPSA

Health Personnel Shortage Area. A medically underserved area in Wisconsin.

ICD-9-CM

International Classification of Diseases, Ninth Revision, Clinical Modification. Nomenclature for medical diagnoses required for billing. Available through the American Hospital Association.

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medically necessary

According to HFS 101.03(96m), Wis. Admin. Code, a Medicaid service that is:

a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
b) Meets the following standards:
   1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
   2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;
   3. Is appropriate with regard to generally accepted standards of medical practice;
   4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
   5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
   6. Is not duplicative with respect to other services being provided to the recipient;
   7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
   8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
   9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

New patient

A patient who is new to the provider and whose medical and administrative records need to be established. A new patient has not received professional services from either the physician or group practice within the past three years.

Glossary (Continued)

On-site supervision

The supervising physician is in the same building in which services are being provided and is immediately available for consultation or, in the case of emergencies, for direct intervention.

PA

Prior authorization. The written authorization issued by the Department of Health and Family Services (DHFS) to a provider prior to the provision of a service.

POS

Place of service. A single-digit code which identifies the place where the service was performed.

QMB Only

Qualified Medicare Beneficiary under the Medicare Catastrophic Health Act. A QMB-only recipient is only eligible for the payment of the coinsurance and the deductible for a Medicare-allowed claim.

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform the provider regarding the processing of the provider's claims.

TOS

Type of service. A single-digit code which identifies the general category of a procedure code.

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